ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
9535 E. DOUBLETREE RANCH ROAD, SUITE 100, SCOTTSDALE, AZ 85258
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

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BY:

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Aug 10, 2017 Case Number: 18-10

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Steve Fernandez
Premise Name: Chino Valley Animal Hospital
Premise Address: 3601 AZ-89
City: Chino Valley State: Arizona Zip Code: 86323
Telephone: 928-636-4382

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Petros Rallas
Address: [redacted]
City: [redacted] State: [redacted] Zip Code: [redacted]
Home Telephone: _____ Cell Telephone: [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

C. PATIENT INFORMATION (1):

Name: Tyson

Breed/Species: Blue nose Pitbull / Dog

Age: 5-6 weeks Sex: M Color: Gray / White

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:

Please provide the name, address and phone number for each veterinarian.

None

E. WITNESS INFORMATION:

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

none or nurses @ [redacted]
Chino Animal Hospital

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: _____

Date: 7-23-2017

* Notes (vet notes)

F. ALLEGATIONS and/or CONCERNS:
Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

Along with this document is Tysons records obtained from the clinic.

List of Concerns:

1. Was hospitalized for 5 day even though they couldnt find anything wrong with him.
2. Along his stay he was undergoing I.V treatment (check notes for details). During his treatment his I.V was left in the left leg for a day too long resulting in an infection. (all information provided in the notes)
3. Keep in mind his weight! (at this stage)
4. Medication administered for the infection they caused. (this resulted in discomfort for the puppy)
5. Day 5 I recieved a call suggesting we put the dog down. After neglecting to do so I retreated the dog and nursed him to a better state (all documented in notes)
6. His leg was not properly bandaged or neither were instructions given to clean just a zip lock bag of disinfectent whipes.

next page

7. After going back once more they told us to wrap it in a cream every 12 hours (twice a day max)
(Keep in mind the medication was upsetting his stomach in result to vomiting, doc assured it was normal side effect)

8. 7/14/17 Tyson was brought back because his leg was no longer a cut/gash but "SKIN PEELING OFF" (this was due to neglect to care or provide us with info to handle his wound)
Pain meds were given which resulted to seizures and his body dropping temp to 92°.
He also vomited everything we were force feeding him which dropped his weight down and dehidration was vissible.

My complaint is how does a licensed vet administer and give all these meds to an underweight puppy who was doing better and after he damaged his leg which resolted to all those meds that killed him.

[List of Meds
1. for his leg (antibiotics
2. pain meds (not FDA Aproved)
3. ointment for leg]

Please review Doc Notes and call me at [redacted] if you need verbal notes from me.

Summary Of The Incident

I, Dr. Estevan Fernandez, saw pet on 7/12 and 7/14 for recheck and owner concerns regarding wound and pain management. Instructed owner on wound management/change bandage two times per day. Owner requested pain management, prescribed Gabapentin 20ml (50mg/ml).

Dr. Estevan Fernandez

Technicians that were involved with any treatments on "Tyson" Rakas

6-28-2017 Jen Lam was the room technician

7-3-2017 Jen Lam was the room technician and the hospitalization intake technician

7-3-2017 Jen Lam was evening treatment technician

7-4-2017 Jen Lam was the morning treatment technician

7-4-2017 Jill Tormo was the evening treatment technician

7-5-2017 Jen Lam was the morning treatment technician

7-5-2017 Robin Mills was the evening treatment technician

7-6-2017 Renee Schubert was the morning treatment technician

7-6-2017 Robin Mills was the evening treatment technician

7-7-2017 Kayte Hecker was the morning treatment technician

7-7-2017 Robin Mills was the evening treatment technician

7-8-2017 John Seliquini was the morning treatment technician

7-10-2017 Shelby Tipton was the room technician

7-12-2017 Shelby Tipton was the room technician

7-14-2017 Kayte Hecker was the room technician

Veterinarians that treated "Tyson" Rakas

6-28-2017 Dr. James Styre

7-3-2017 Dr. James Styre

7-4-2017 Dr. James Styre

7-5-2017 Dr. Estevan Fernandez

7-6-2017 Dr. James Styre

7-7-2017 Dr. James Styre

7-8-2017 Dr. Michael Kahan

7-10-17 Dr. James Styre

7-12-17 Dr. Estevan Fernandez

7-14-17 Dr. Estevan Fernandez

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Robert Kritsberg, D.V.M. - Chair
Donald Noah, D.V.M.
Adam Almaraz
Amrit Rai, D.V.M.
Tamara Murphy

STAFF PRESENT: Tracy Riendeau, CVT – Investigations
Sunita Krishna, Assistant Attorney General

RE: Case: 18-10
Complainant(s): Petros Rakas
Respondent(s): Estevan Fernandez, DVM (License: 3411)

SUMMARY:
Complaint Received at Board Office: 8/10/17
Committee Discussion: 10/10/17
Board IIR: 11/15/17

APPLICABLE STATUTES AND RULES:
Laws as Amended July 2014 (Salmon); Rules as Revised September 2013 (Yellow)

On July 3, 2017, "Tyson," a 6-week-old male Pitbull was hospitalized at Chino Valley Animal Hospital for continued vomiting and diarrhea. Diagnostics and treatments were performed; the dog did not improve and was discharged five days later for Complainant to continue care.

Complainant noted an infection on the dog's leg at the catheter site and brought the dog in for care.

Complainant contends Respondent was negligent in the dog's care.

Complainant was noticed and appeared telephonically.
Respondent was noticed and appeared telephonically. Attorney, David Stoll, was present.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Petros Rakas*
- Respondent(s) narrative/medical record: *Estevan Fernandez, DVM*

PROPOSED 'FINDINGS of FACT':

1. On June 28, 2017, the dog was presented to Respondent's associate, Dr. Styre, for diarrhea and not eating. Complainant also reported that the dog vomited a small amount the previous day. The dog was examined and the dog was quiet, alert, and responsive; rule-out was parvo vs other. The parvo test was negative; the dog had no interest when a/d was offered therefore Dr. Styre recommended a long term monitoring program. The dog was administered a DHPPC vaccine and pyrantel dewormer and discharged with metronidazole suspension and instructions to return the following day if no improvement.

2. On July 3, 2017, the dog was presented to Dr. Styre for not eating for 5 days, diarrhea with blood and vomiting after drinking water. Complainant reported that he had taken the dog to Prescott Animal Hospital and had tested negative for Parvo there as well. The dog was examined and it was noted the dog was dehydrated, had pale pink mucous membranes and was thin. Dr. Styre's assessment was gastroenteritis 1st degree vs 2nd degree. Blood was collected for testing (glucose in-house = 198) and the dog was hospitalized on IV fluids – Lactated Ringers with 5% dextrose – and was administered IV ampicillin and metronidazole. Radiographs were performed and revealed a ground glass appearance – rule out peritonitis vs normal puppy.

3. Dr. Styre called Complainant to give an update of the dog; he had urinated and passed diarrhea. Blood revealed an elevated BUN and WBC, and a low RBC and HCT. Dr. Styre offered a referral to a 24 hour emergency clinic, Complainant declined.

4. The following day, the dog did not vomit but did have diarrhea. There was no interest in food, he was medicated with ampicillin and metronidazole and IV fluids were increased. Later that day, the dog was administered cerenia and a blanket and warming bags were placed with the dog due to low temperature. Metoclopramide was added to the IV fluids. Dr. Styre gave Complainant an update on the puppy.

5. On July 5, 2017, Respondent cared for the puppy. The puppy was examined and due to the low temperature, more warm bags were placed in the kennel. No vomiting or diarrhea was noted and Respondent instructed staff to feed a/d every 2 hours. Ampicillin and metronidazole was administered. Later that evening, ampicillin and metronidazole was given and Respondent ordered the following:

a. Zofran 2mg/mL, 0.01mL IV;
b. B12 complex 3000mcg/mL, 0.001 SQ;
c. 1 capsule of proviable; and
d. Hetastarch 6% 5mLs IV slowly.

6. On July 6, 2017, Dr. Styre examined the dog and continued treatment with ampicillin, metronidazole, and IV fluids. The dog was not eating or drinking on his own; a/d and water was being force fed. The dog could not stand or walk on his own. Dr. Styre contacted Complainant with an update – he explained that if the dog does not improve by the following day, they may need to consider humane euthanasia. Evening treatments were administered and the dog was force fed.

7. On July 7, 2017, Dr. Styre examined the dog. Hot water bags were added due to hypothermia

and the dog was force fed. Open bleeding sores were noted on the dog's mouth and he appeared to be struggling to breathe when trying to move. Dr. Styre elected to discontinue to metronidazole in case that was causing issues. Blood work was performed and Dr. Styre updated Complainant with results and plan. He explained that he discontinued ampicillin -- switched to Clavamox -- and metronidazole and would continue supportive care; prognosis was guarded.

8. On July 8, 2017, Dr. Kahan was overseeing the care of the dog. The dog was examined and was hypothermic, weak, and unable to sit, walk or hold head up. There was a swelling in the paw and arm – IV catheter appeared to be blown. The dog was force fed a/d, and administered Clavamox and proviable. Dr. Kahan spoke with Complainant who elected to take the dog home. Complainant was instructed on how to keep the dog warm, administer SQ fluids and syringe feed. The dog was discharged with Clavamox and proviable with instructions to follow up Monday. Per Complainant's request, Dr. Kahan gave Complainant a dose to administer CBD oil.

9. On July 10, 2017, the dog was presented to Dr. Styre for a recheck. Complainant felt the dog appeared to be doing better. Dr. Styre noted that there was a slight infection at the catheter site on the right front leg. The plan was to continue Clavamox and fluids and recheck as needed.

10. On July 12, 2017, the dog was presented to Respondent for a recheck of the right front leg. Complainant reported that the dog had eaten the day before but did not eat on this day. He believes the infection in the leg is causing the dog to not eat. Respondent examined the dog and noted the right front leg swelling was down; there was an open wound and a patch of dead skin that would slough. The leg was bandaged with vet wrap, telfa pad and silver cream 1%. Respondent recommended changing the bandage daily and rechecking in 5 – 7 days.

11. On July 14, 2017, the dog was presented to Respondent for a recheck due to skin sloughing. Respondent examined the dog and found a 1cm round open wound. He called the Complainant and recommended changing the bandage twice a day. The dog was discharged with Gabapentin 250mg/50mL, 20mLs; give 0.2mLs orally every 12 hours as needed for pain.

12. Complainant expressed concerns that the pain medication caused the dog to seize. He was vomiting everything they force fed and was dehydrated. Complainant believes that too many medications were given the dog – antibiotics, pain medication and ointment for the leg – which led to his death.

COMMITTEE DISCUSSION:

The Committee discussed that Complainant suspected that the catheter was left in too long causing the dog's ultimate demise. Catheters can blow and cause sloughing. However, the dog had some underlying issue, possibly parvo despite the negative test. The medications administered and dispensed to the dog were appropriate.

Respondent's care and treatment of the dog was appropriate.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that no violations of the *Veterinary Practice Act* occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board:

Dismiss this issue with no violation.

Vote: The motion was approved with a vote of 5 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.

Tracy A. Riendeau, CVT
Investigative Division